

Subject: Re: Review the documents meticulously of the name, signatures and dates, and confirm you did it or not.

From : minhye park

To: JSL LAW OFFICES, P.C.

Date: 201-07-05 1308 PM

So these 4 pages are the ones I wrote when I first went to the clinic, and where marked "x" is not my handwriting. Other than these four pages of documents, they are not written by me, and I have never seen them before.

Subject: Re: Review the documents meticulously of the name, signatures and dates, and confirm you did it or not.

From : minhye park

To: JSL LAW OFFICES, P.C.

Date: 201-07-05 11:55

I've checked and I've written only the parts I've circled in red, and the rest of them are not the papers I've written. Other documents are the first time I look at them, and I've never seen it or heard it. That's not my handwriting, it's someone else's. Not only did I speak English, but I didn't understand spoken English. I have never heard about any side effects or anything about surgery before or after the surgery and the doctor lied to me even when he saw the ultrasound that the baby was still there and growing because the surgery went wrong.

I just heard the doctor said that the surgery went good, without knowing the baby was still growing, and I took the contraceptive pill right after the surgery, and I came to Korea to find out that the fetus was still alive. When I still think about what happened then, my whole body shakes and I feel so angry. I don't know what these documents are about, and the only part I circled is my handwriting, and the rest of the documents that I've never seen before. Those are not my handwriting. Now please stop this doctor's lying and I want to end this pain.

Affidavit of Translation

I, Soohyun Park, am fluent in English and Korean. I hereby certify that I have translated and verified the following document(s) which is/are attached to this Affidavit:

Description of document(s): (title or type, document date, number of pages)
two email replies, sent date 7/5/21 , 1 page

I further certify that, to the best of my knowledge, the attached document(s) written in English is/are a true and accurate translation of the attached document(s) written in Korean.

Soohyun Park
(Signature of Translator/Verifier)

Soohyun Park
(Print Name)

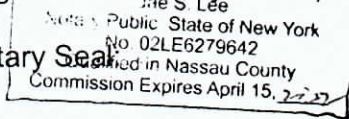
=====

STATE OF New York
COUNTY OF Nassau

Subscribed and affirmed, or sworn to, before me on this 5th day of August, 2021, by Soohyun Park.

[Signature]
(Signature of Notary Public)

Notary Seal



Jie Lee
(Print Name)

My commission expires:

Subject **Re: 이름과 사인, 날짜 등을 꼼꼼히 확인 하시고, 본인이 하신 것이 맞는지 연락 주세요.**
From 박민혜 <jindov12@naver.com>
To JSL LAW OFFICES, P.C. <office@lawjsl.com>
Date 2021-07-05 13:08



- EC290651-51B1-40AE-8B12-5ED375B3B16E.jpeg(~296 KB)
- EFE60BA0-4A21-44A9-B207-839242BF4F78.jpeg(~348 KB)
- 2430BDEE-A0B1-428D-90BE-1F74D7BA78CD.jpeg(~245 KB)
- 9427492E-7CF2-4549-BD97-33450C0D8CC8.jpeg(~413 KB)

이렇게 4장은 제가 처음 병원에 갔을 때 작성한게 맞고 x친 부분은 제 글씨가 아닙니다 이 4장을 제외한 나머지 서류는 제가 쓴게 아니고 처음보는 서류들입니다

-----Original Message-----

From: "JSL LAW OFFICES, P.C."<office@lawjsl.com>

To: "박민혜"<jindov12@naver.com>;

Cc:

Sent: 2021-07-06 (화) 01:58:12 (GMT+09:00)

Subject: Re: 이름과 사인, 날짜 등을 꼼꼼히 확인 하시고, 본인이 하신 것이 맞는지 연락 주세요.

이것도 보세요.

Very truly,

JSL Law Offices, P.C.
(Main Office)
626 RXR PLAZA
UNIONDALE, NY 11556

Tel: (718) 461-8000
Fax : (866) 449-8003
www.lawjsl.com

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On 2021-07-05 11:55, 박민혜 wrote:

- > 확인해보니 제가 직접 쓴 글씨는 빨간색으로
- > 동그라미 친 부분만
- > 제가 쓴 거고 나머지는 제가 쓴 글자가 아닙니다
- > 다른 서류들은 아예 처음 보는거고 저런 서류들을
- > 저는 본 적도
- > 그에 대한 설명을 들은적도 없습니다 저건 제 글씨가
- > 아니고 다른사람 글씨입니다 저는 영어를 못해서
- > 무슨말인지 알아듣지도 못할뿐더러 수술전이나
- > 수술후에도 전혀 부작용이나 수술에 관한
- > 어떤글이라거나 얘기도 듣지도 보지도 못했고
- > 심지어 수술이 잘못되서 아기가 크고 있는걸
- > 초음파로 보고도 의사는 저에게 거짓말을 했습니다

> 수술이 잘못되서 아기가 크고있는지도 모르고
> 수술이 잘되었다는 의사 말만 듣고 수술 후 피임약을
> 바로 복용했으며 한국에 와서 아기가 있다는걸 알게
> 되었습니다 아직도 그때 생각을 하면 온 몸이
> 떨릴정도로 화가 납니다 저는 이 서류들이 무슨
> 내용인지도 모르고 제가 동그라미 친 부분만 제
> 글씨가 맞고 나머지 서류들은 본 적도 없는 처음보는
> 글씨입니다 이것은 제 자필이 아닙니다 이제 제발 그
> 의사가 거짓말을 그만하고 이 고통을 끝내고
> 싶습니다
>
>
> -----Original Message-----
> From: "JSL LAW OFFICES, P.C."<office@lawjsl.com>
> To: <jindov12@naver.com>;
> Cc:
> Sent: 2021-07-06 (화) 00:30:56 (GMT+09:00)
> Subject: 이름과 사인, 날짜 등을 꼼꼼히 확인 하시고,
> 본인이 하신 것이 맞는지 연락 주세요.
>
> 첨부서류에 있는 이름과 사인, 날짜 등을 꼼꼼히
> 확인 하시고, 본인이 하신 것이 맞는지 연락 주세요.
>
> --
> Very truly,
>
> JSL Law Offices, P.C.
> (Main Office)
> 626 RXR PLAZA
> UNIONDALE, NY 11556
>
> Tel: (718) 461-8000
> Fax : (866) 449-8003
> www.lawjsl.com [1]
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~296 KB

QuestQuantum™

David D. Kim, MD
Obstetrics and Gynecology
143-16 Sanford Ave., 1st Floor
Flushing, NY 11355

Tel. 718-445-1700
Fax. 718-445-3097

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclosed protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how the protected health information about you is used or disclosed for treatment, payment, or health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that :

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
3. The practice reserves that right to change the Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
5. The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
6. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by

Park Min hye

11/16/17

(printed name of patient or representative)

Signature (I have received a copy of the privacy notices)

Date

Witness:

(Printed name of Practice representative)

Date

Signature

Date

QuestQuantum™

David D. Kim, MD
Obstetrics and Gynecology
143-16 Sanford Ave., 1st Floor
Flushing, NY 11355

Tel. 718-445-1700
Fax. 718-445-3097

Patient Demographic Insurance Form

Name(이름) : Park Min hye Date(날짜): 2017. 11. 16

Address(주소): 43-11 220 St Bayside NY 11361

City: _____ State: _____ Zip Code: _____

Date of Birth (생년월일): [REDACTED] Cell Phone(전화번호): 917 683 3535
Home Phone: _____
Work Phone: _____

Primary Insurance Carrier: _____

Insurance ID #: _____ Date Insurance Started: _____

Reason for Visit: _____

Referring Doctor / Friend: _____

Would you like to have a female present as a chaperone during your exam? YES ☒ NO

(검사도중 여성분이 같이 계시길 원하시나요?)

Would you like to have a Korean translator?(한국어 통역이 필요하신가요?) ☒ YES NO

May Dr. Kim's office call you and leave a message? (음성메세지를 남겨도 괜찮은가요?) ☒ YES NO

The provider (David D. Kim, MD) may release to governmental agencies, insurance carriers, or their designated agents or the legal or financial departments representing me or the provider, all information needed to substantiate payment for my medical care and permit representative thereof to examine and make copies of records in relation to such care and treatment.

I hereby assign, transfer and set over to David Kim, MD monies and/or benefits to which I may be entitled from governmental agencies, and insurance carriers or others who are financially liable for my hospitalization and/or medical care to cover the costs of treatment rendered to myself or dependent I will contact David Kim, MD in writing within 30 days of any changes to my insurance and; or of the above information and agree to pay him in full any deductible and co-payment my insurance requires me to pay.

Signature of Patient(서명):  Date(날짜): 2017. 11. 16

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CHECK THE ELIGIBILITY OF YOUR
INSURANCE BEFORE THE VISIT. IF
YOUR INSURANCE IS NOT ACTIVE AT
THE TIME OF SERVICE, YOU HAVE
TO PAY FOR THE VISIT.

SIGNATURE OF PATIENT: _____



DATE: _____

2017. 11. 16

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린치증후군 및 유전성 유방암 및 난소암 증후군에 대한 위험 평가

환자 이름: Park Min hye

담당 의사: _____

생년월일: 681215작성 일자: 11/16/17

지침: 귀하와/또는 귀하 가족 (모계(어머니) 또는 부계(아버지)쪽 모두)에 해당하는 경우 Y에 동그라미 표시를 하십시오. 각 내용 다음에, 귀하와의 관계 및 진단 연령을 적으십시오. 귀하 및 다음과 같은 가족 구성원이 해당됩니다:

부모, 형제, 자매, 아들, 딸, 조부모, 손자녀, 숙모, 숙부, 조카, 질녀,
배다른 형제, 사촌, 증조부 및 증손자녀

각각의 항목은 개별적으로 답변하여야 합니다; 질문에 답할 때 동일한 암 진단을 한 번 이상 적을 수 있습니다. 본 설문지는 유전성 유방 및 난소암 증후군, 그리고 림프 증후군의 일반적인 양상에 대한 선별검사 도구입니다. 이 내용을 귀하의 의료진과 공유하여 귀하의 유전성 암 위험을 판정하는데 도움이 되도록 하십시오.

대장 및 자궁암	자신	가족	진단 시 연령
예 <u>아니오</u> 50세 이전에 자궁(자궁내막) 암			
예 <u>아니오</u> 50세 이전에 대장암			
예 <u>아니오</u> 동일인 또는 부계 또는 모계 쪽에서 2건 이상의 림프 증후군*			

*다음에 포함된 림프 증후군 관련 암: 대장/직장, 자궁/자궁내막, 난소, 위, 신장/요도, 달관, 수장, 췌장, 뇌, 그리고 피지 선종/암종

유방 및 난소암	자신	가족	진단 시 연령
예 <u>아니오</u> 50세 이전에 유방암			
예 <u>아니오</u> 난소암			
예 <u>아니오</u> 동일인 또는 부계 또는 모계 쪽에서 2건의 원발성(무관한) 유방암*			
예 <u>아니오</u> 남성 유방암			
예 <u>아니오</u> 삼중 음성 유방암† (병리검사상 ER-, PR-, HER2-)			
예 <u>아니오</u> 모든 연령대에서 3건 이상의 HBOC 관련 암‡			
예 <u>아니오</u> 모든 연령대에서 HBOC 관련 암의 아시케나지 유대인(Ashkenazi Jewish) 조상 및 개인 또는 가족력‡			

†HBOC 관련 암은 유방(DCIS 포함), 난소, 췌장, 그리고 공격성 전립선 암을 포함합니다.
‡가족은 부계 및 모계의 1, 2, 3차 직계 존/비속을 포함합니다.

예 아니오 귀하나 귀하의 가족 중에 유전성 암 위험에 대한 검사를 받은 사람이 있습니까?
있는 경우 기록해 주십시오:

환자 서명	일자	□ 환자에게 유전자 검사 제인 결과: ○ 수락 ○ 거절
설문 검사자 용		
□ 추가적인 위험 평가 및/또는 유전자 검사 대상자: ○ 림프 ○ HBOC		
□ 검토를 위해 환자에게 일린 정보		
□ 추적관찰 내원 일정	날짜: _____	의료진 서명

† 삼중 음성 유방암에 대해 자세히 아시려면 귀하의 의료진에게 물어 보십시오.
의료 협회 가이드라인에 근거한 평가 기준. 개별 협회 가이드라인에 대해서는 웹사이트를 방문하십시오.
Myriad 및 Myriad 로고는 미국 및 기타 법적 관할지에서 Myriad Genetics, Inc.의 상표 또는 등록 상표입니다. ©2013

PCRA/09-13 MYRIAD.

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